

Treatment of Carcinoma of the Uterine Cervix*

A Commentary on Current Methods

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SEVERAL DISQUIETING STATEMENTS in the recent American Cancer Society monograph on Cancer of the Female Genital Tract¹ warrant further discussion.

First, the suggestion that operation with conservation of the ovaries is the treatment of choice "if the lesion is small and the patient is young, i.e., less than 35 years" should be more fully explained. This approach is widely accepted in proven cases of carcinoma *in situ*. However, it is probable that to most readers of this monograph, the words "small" and "early" with reference to carcinoma of the cervix imply a lesion of the clinical Stage I type. The ever-increasing tendency to stress the surgical approach in so-called early carcinoma of the cervix receives a stimulation that surely is not the intent of the authors. It is quite generally recognized that regardless of the trends of preference in any hospital or clinic, be they toward operation or irradiation, both forms of treatment should be available. Indeed, following a competent unbiased appraisal of the patient and the cancer, one patient with an early lesion will be advised to have operation, while for the next patient with a similar lesion radiation will be recommended.

Second, the suggestion in the monograph that the scope of the surgical excision be determined on the basis of frozen section examination of the obturator and iliac nodes implies a competency of tissue evaluation difficult to accept. Limiting immediate examination to these two groups of nodes seems to neglect the possibility of metastatic involvement elsewhere. Next to the paracervical (ureteric) and the small parametric nodes, the obturator and the iliac groups are most frequently involved. However, bypassing of these two groups with involvement of the nodes of the hypogastric or sacral groups occurs frequently enough to be considered of major importance. In material observed by the author, involve-

• A monograph on Cancer of the Female Genital Tract published by the American Cancer Society seems to put greater than warranted stress on the value of operative treatment as compared with radiotherapy of "small" or "early" lesions of the uterine cervix. The terms themselves may be misleading in that many readers may mistakenly take them to mean Stage I lesions. A diagnosis of Stage I is no assurance that extension has not occurred (as it had in 23.5 per cent of 17 cases of Stage I carcinoma observed by the author).

In addition, there is suggestion in the monograph that the extent of operation may be reliably determined on the basis of frozen section examination of the obturator and iliac nodes. This overlooks the considerable possibility of metastasis that skips these groups and extends to others beyond (as it did in one of the 17 cases).

Moreover, preoperative diagnosis of the stage of a lesion is not wholly reliable. In a series of 37 cases observed by the author in which the preoperative diagnosis was Stage I carcinoma of the cervix, pathological examination of tissues, after total hysterectomy of the Wertheim type, revealed that in nine cases the growth was actually at a more advanced stage. Upon further examination of tissues it was noted also that the excision was inadequate in 33 of the 37 cases.

ment of nodes was noted at autopsy in four of 17 untreated patients (23.5 per cent) with Stage I carcinoma of the cervix. If a fifth case in which there was involvement of two positive small anomalous nodes in the subvesical space were included, the incidence of nodal involvement in the 17 cases of proven Stage I carcinoma of the cervix would be 29.3 per cent. In two of the four cases with "positive" regional nodes, the obturator group was involved; in another the obturator and external iliac, and in the fourth the left lateral sacral group. It is of further interest that the involvement in the "positive" nodes was overlooked in two of the four cases when the study was limited to three blocks of each node. Not until re-study was

*This commentary has been prepared, at the request of the Cancer Commission of the California Medical Association, by a member of the Commission particularly qualified by wide experience in gynecologic surgery and by original investigational studies of uterine cancer.

The Cancer Commission and its Advisory Committee are in unanimous disagreement (see page 97 of this issue of CALIFORNIA MEDICINE) with some of the therapeutic implications in the widely distributed monograph¹ referred to in the text. In particular, the Commission believes that the emphasis on surgical treatment of carcinoma of the cervix is ill-advised. From the standpoints of wider applicability, lesser morbidity, and better over-all end results, radiation therapy is superior to operation in the majority of patients with this form of cancer.

carried out with five blocks was the nodal involvement noted. It is certainly within the realm of reason that if a more thorough examination of each node were carried out in such cases, the observed incidence of involvement would be greater. Hence, the proposal that the presence or absence of malignant emboli in a node can be detected consistently by a hurried frozen section examination is certainly most questionable.

Of further interest is the matter of establishing the true clinical status of the disease before operation or necropsy. In a series observed by the author, a study was made of tissue and organs in 37 cases in which the diagnosis was Stage I cancer of the cervix and the treatment was the Wertheim type of total hysterectomy and lymphadenectomy. The following data were obtained: In eight of the 37 cases (21.5 per cent) the growth was considered Stage II and in one case (2.7 per cent) Stage III. Thus, in 24 per cent of the 37 cases in which thorough and competent preoperative examinations were carried out, the lesion was found to be in a more advanced stage than had been diagnosed. Further examination of the organs and tissues revealed inadequate excision

in 33 (89 per cent) of the cases. These observations are both disturbing and discouraging in the assay of the various ideas of what constitutes radical operation for carcinoma of the cervix. Certainly no half-way measure is conscionable. Since the possibility of unsuspected extension is always present, if operation is to be done at all it should be adequate.

Recognizing that the Cancer Society's monograph is mailed to some 65,000 physicians and possibly is accepted as the final word by a large number, the author believes stress should have been put on the value of irradiation, except in the occasional cases in which the growth is radio-resistant. To stress the value or superiority of an approach that possibly has proven worthwhile in the hands of a very competent gynecological surgeon in a highly organized clinic disregards the tendency of too many self-admitted competent surgeons to accept this *modus operandi* as the final answer.

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REFERENCE

1. Traut, H. F., and Benson, R. C.: Cancer of the Female Genital Tract, American Cancer Society, Inc., New York, N. Y., 1954.

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A Personal Message to YOU:

As your personal physician I consider it both a privilege and a matter of duty to be available in case of an emergency. But, being only human you can understand that there are times when I may not be on call. I might be at a medical meeting outside the city, on a bit of a vacation—or even ill.

Consequently, I thought it would be a good precaution if—on this gummed paper which you can paste in your telephone book or in your medicine cabinet—I listed numbers where I can be reached at all times. Also, the number of a capable associate as an added service. Here they are:

_____ OFFICE	_____ HOME	_____ MY DOCTOR
_____ OFFICE	_____ HOME	_____ ASSOCIATE



Sincerely,

_____, M.D.

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